

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07363

7367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>West Street</u>	
3. NAME OF DECEASED (Type or print) First <u>ZUZANNA</u> Middle <u>ADAM</u> Last <u>NICHOLAS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>RIGA, LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SKIERS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>MRS. RAYMOND JOSEPH, BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/14</u> 19 <u>58</u> , to <u>6/11</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/11</u> 19 <u>58</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. J. Ellis Jr.</u> M.D. <u>Salisbury, Md</u>		DATE SIGNED <u>6-13-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVORGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>			

CERTIFICATE OF DEATH

DATE OF BIRTH

THIS CERTIFICATE SHALL BE SIGNED BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO SIGN SUCH A CERTIFICATE

CLASS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

SEX

IN DEATH OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

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CAUSE OF DEATH

7419

CERTIFICATE OF DEATH

Reg. Dist. No.

07364

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALFRED Middle AUSTIN Last ALBRIGHT				4. DATE OF DEATH Month 6 Day 10 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/58-1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 10 Days 19	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Veteran		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Emsley Albright				14. MOTHER'S MAIDEN NAME Elizabeth Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Spanish American & World War #1		17. INFORMANT Mrs Pearl Albright, Md.		Address Nanticoke	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) After ischaemic Heart Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 year 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 April, 1958 to 10 June, 1958 that I last saw the deceased alive on June, 1958 , and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Nanticoke, Md. DATE SIGNED 6/10/58							
ACTUAL SIGNATURE Richard H. Saunders				PHYSICIAN'S NAME (Type) Richard H. Saunders Nanticoke, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORY Wic. Mem. Park Cem.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Corrie L. B. Bessie				24a. REC'D BY REGISTRAR DATE JUN 17 58		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

7368

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Hazel Ave				d. STREET ADDRESS 232 Hazel Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle BRAXTON Last BAKER				4. DATE OF DEATH Month JUNE Day 6 th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0 Days 26	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of		10b. KIND OF BUSINESS OR INDUSTRY Concrete Block Co.		11. BIRTHPLACE (State or foreign country) Whaleyville		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ulysess R. Baker				14. MOTHER'S MAIDEN NAME Annie Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Gordy Parker (Niece) Address 232 Hazel Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from February 19 58 to June 6, 19 58 , that I last saw the deceased alive on June 6, 19 58 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Road Salisbury, Md. DATE SIGNED June 9, 1958							
ACTUAL SIGNATURE Thomas C. Hill M.D.		PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Pine Bluff Road Salisbury, Md. Jun. 1958					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 10 '58	24b. REGISTRAR'S SIGNATURE W. Leach	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7369

CERTIFICATE OF DEATH

07366

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>VIENNA</u> <u>094-2</u>			
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>BASSETT</u> Last <u>BASSETT</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bassett</u>				14. MOTHER'S MAIDEN NAME <u>Martha Christopher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Miss Essie Bassett</u>		17. INFORMANT Address <u>Vienna</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) <u>Myocardial Infarct</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>57</u> , to <u>6-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Ellis</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-7-58</u>			
PHYSICIAN'S NAME (Type) <u>Ruth S. Killoughly, East New Market</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Vienna</u>		22d. LOCATION (City, town, or county) (State) <u>Vienna Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth S. Killoughly, East New Market</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carb. Smith</u>	

7370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GEN. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES WILLIAM Bennett</u>				4. DATE OF DEATH Month Day Year <u>June 28 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 12, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COUNTRY TREASURE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>SAMUEL W. BENNETT</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE E. VENABLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>CHARLES W. BENNETT, Jr. - Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Mild diabetes + Hypertension</u> 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u> <u>4 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 10 1957</u> to <u>6/28 1958</u> , that I last saw the deceased alive on <u>6-28 1958</u> , and that death occurred at <u>2:57 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. B. Smith</u> M.D. <u>Med. Center Sky Md.</u>				DATE SIGNED <u>6/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wm. B. Smith, SALISBURY, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/30/1958</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u> ADDRESS <u>SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>			
Signature <u>George C. Nepe</u>				24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

7371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Pen Gen. Hosp		d. STREET ADDRESS Lillian St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle AMELIA Last BISHOP		4. DATE OF DEATH Month JUNE Day 5 th 19 Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 1 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Mardela Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John George Pollitt		14. MOTHER'S MAIDEN NAME Mary Elizabeth Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Carl William Pollitt (Brother) Hebron Maryland	
17. INFORMANT Mr. Carl William Pollitt (Brother) Hebron Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Occlusion DUE TO Arteriosclerotic heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syn- DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-17 , 19 58 , to 6-5 , 19 58 , that I last saw the deceased alive on 5-12 , 19 58 , and that death occurred at 4:27 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) June 7 / 58 DATE SIGNED			
ACTUAL SIGNATURE Earl L. Royer M.D.			
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer 407 Camden Ave. Salisbury Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Hebron, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR June 10 '58		24b. REGISTRAR'S SIGNATURE Ch. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7372

CERTIFICATE OF DEATH

Item 9 Film C230 6-11-58 et

Reg. Dist. No.

07369

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>2 wks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u>		e. STREET ADDRESS <u>427 Penn. Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Clifton</u> Last <u>Bounds</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>6</u> Min.	IF UNDER 24 HRS. Months <u>6</u> Days <u>7</u> Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco and Confectionery</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James Bounds</u>		14. MOTHER'S MAIDEN NAME <u>Ann Elizabeth King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-3519</u>	
17. INFORMANT <u>Mrs. Alice A. Bounds</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 22</u> to <u>June 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>58</u> , and that death occurred at <u>9:03 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>		DATE SIGNED <u>6-6-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/5/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co/</u>		ADDRESS <u>Salisbury, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

7373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solihuey</u>		c. LENGTH OF STAY IN 1b <u>16 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		23 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>242, Martin Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OLLA</u> First <u>Brittingham</u> Middle <u>Levin</u> Last <u>Brittingham</u>				4. DATE OF DEATH <u>June 24</u> 19 <u>58</u> Month <u>June</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5-1887</u>	9. AGE (In years last birthday) <u>70/10/19</u>	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>19</u>		11. IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>7</u>	
13. FATHER'S NAME <u>Filmore Pusey</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Bromley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>M. Levin Brittingham, Snow Hill, Md</u> Address <u>Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Metastases + Effusion</u> DUE TO <u>Lymphosarcoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphosarcoma</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	Month <u>19</u>	Day <u>19</u>	Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>6.8</u> 19 <u>58</u> , to <u>6.24</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6.24</u> 19 <u>58</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Brille</u>				ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>6.24.58</u>			
PHYSICIAN'S NAME (Type) <u>Clayton E. Kennis</u>				ADDRESS <u>Snow Hill, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Kennis</u>				ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>Al. Leach</u> 24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Pittsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen. Hospital			d. STREET ADDRESS In Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLA Middle AMELIA Last CAREY			4. DATE OF DEATH Month JUNE Day 15th Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1894		9. AGE (In years last birthday) 63 yrs. 6 Months 17 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Chincoteague, Virginia	
13. FATHER'S NAME Thomas M. Truitt			14. MOTHER'S MAIDEN NAME Della Kollock		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Walter H. Carey (Husband) Address Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 816X DUE TO (b) Thrombophlebitis Rt leg Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Fracture Rt. ankle					INTERVAL BETWEEN ONSET AND DEATH Sudden 2 wks 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pancreas auto collected in another car			
20c. TIME OF INJURY Month. Day, Year Hour a. m. 5-28 p. m. 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 50	20f. (City or town) Pittsville	(County) Wicomico	(State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 16 1958	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY Pittsville Cem. (Old Part)		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR June 18 '58	24b. REGISTRAR'S SIGNATURE W. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10

7375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Oak Dale Road		d. STREET ADDRESS 1 212 Oak Dale Road	
3. NAME OF DECEASED (Type or print) First LEAH Middle CATHERINE Last CLEARY		4. DATE OF DEATH Month JUNE Day 2nd Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work-Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Turner White		14. MOTHER'S MAIDEN NAME Emma Ennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Gladys Baysinger (Daughter) Address 212 Oak Dale Road - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1949 to 6/2 , 19 58 , that I last saw the deceased alive on 6/1 , 19 58 , and that death occurred at 2:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Gramse		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED June 19 1958	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		402 S. Division St. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 9 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07373

7376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annals General Hospital</u>		d. STREET ADDRESS <u>87D#1 Bas 137</u>	
3. NAME OF DECEASED (Type or print) First <u>ELLA Belle</u> Middle <u>Collins</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cobred</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Collins</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Evelyn Allen Snowhill md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/5</u> , 19 <u>58</u> , to <u>6/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>58</u> , and that death occurred at <u>12:50 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Elliot</u> M.D.		ADDRESS (Street, city or town, state) <u>Galesburg, Md.</u> DATE SIGNED <u>6-13-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ginsley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>-new church, VA-</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
JAMES H. HARRIS		Male		65		10/15/1918		10:30 AM		Home	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
Farmer		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF BIRTH		16. DATE OF BIRTH		17. PLACE OF BIRTH		18. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
19. PLACE OF BIRTH		20. DATE OF BIRTH		21. PLACE OF BIRTH		22. DATE OF BIRTH		23. PLACE OF BIRTH		24. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
25. PLACE OF BIRTH		26. DATE OF BIRTH		27. PLACE OF BIRTH		28. DATE OF BIRTH		29. PLACE OF BIRTH		30. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF BIRTH		34. DATE OF BIRTH		35. PLACE OF BIRTH		36. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
37. PLACE OF BIRTH		38. DATE OF BIRTH		39. PLACE OF BIRTH		40. DATE OF BIRTH		41. PLACE OF BIRTH		42. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
43. PLACE OF BIRTH		44. DATE OF BIRTH		45. PLACE OF BIRTH		46. DATE OF BIRTH		47. PLACE OF BIRTH		48. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
49. PLACE OF BIRTH		50. DATE OF BIRTH		51. PLACE OF BIRTH		52. DATE OF BIRTH		53. PLACE OF BIRTH		54. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
55. PLACE OF BIRTH		56. DATE OF BIRTH		57. PLACE OF BIRTH		58. DATE OF BIRTH		59. PLACE OF BIRTH		60. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. PLACE OF BIRTH		64. DATE OF BIRTH		65. PLACE OF BIRTH		66. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
67. PLACE OF BIRTH		68. DATE OF BIRTH		69. PLACE OF BIRTH		70. DATE OF BIRTH		71. PLACE OF BIRTH		72. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
73. PLACE OF BIRTH		74. DATE OF BIRTH		75. PLACE OF BIRTH		76. DATE OF BIRTH		77. PLACE OF BIRTH		78. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
79. PLACE OF BIRTH		80. DATE OF BIRTH		81. PLACE OF BIRTH		82. DATE OF BIRTH		83. PLACE OF BIRTH		84. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
85. PLACE OF BIRTH		86. DATE OF BIRTH		87. PLACE OF BIRTH		88. DATE OF BIRTH		89. PLACE OF BIRTH		90. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. PLACE OF BIRTH		94. DATE OF BIRTH		95. PLACE OF BIRTH		96. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	
97. PLACE OF BIRTH		98. DATE OF BIRTH		99. PLACE OF BIRTH		100. DATE OF BIRTH		101. PLACE OF BIRTH		102. DATE OF BIRTH	
Maryland		10/15/1918		Maryland		10/15/1918		Maryland		10/15/1918	

7420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sirman Middle Fulton Last Cook		4. DATE OF DEATH Month June Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1909
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Marvil Package Co.	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Alberta Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-01-0561	
17. INFORMANT Mrs. Ruby Stanley, Mardela Springs, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO 434.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dilatation, & ecced to function DUE TO (c) Saw him fresh few days before death			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/3/58 to June 31, 1958 , that I last saw the deceased alive on June 7 , 19 58 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mardela Springs, Md DATE SIGNED W. J. Frampton			
ACTUAL SIGNATURE W. J. Frampton M.D. Mardela Springs, Md			
PHYSICIAN'S NAME (Type) W. J. Frampton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 11, 1958	22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery	22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '58	24b. REGISTRAR'S SIGNATURE W. J. Frampton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7377

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 703 Alvin Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CAROLYN First SUE Middle COPPINGER Last				4. DATE OF DEATH JUNE Month 24 Day th 19 58 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1909	9. AGE (In years lost birthday) 48 yrs.	IF UNDER 1 YEAR 6 Months 6 Days	IF UNDER 24 HRS. 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Chesser				14. MOTHER'S MAIDEN NAME Laura Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Walter Paul Coppinger (Husband) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary fibrosis and Hydrothorax 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma and Radiation Effect DUE TO (c) Carcinoma of the Breast INTERVAL BETWEEN ONSET AND DEATH 9 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 30, 1958 to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 4:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED June 25, 1958							
ACTUAL SIGNATURE Thomas C. Hill, Jr. M.D.							
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill				Pine Bluff Rd Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Gates of Heaven - Silver Springs, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR JUN 27 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7421

CERTIFICATE OF DEATH

08509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs-Rural		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo		d. STREET ADDRESS San Domingo	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ode Middle Royal Last Cornish		4. DATE OF DEATH Month June Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cornish		14. MOTHER'S MAIDEN NAME Jane Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Ella Cornish, Mardela Springs, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidemic Carcinoma of Bladder 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 mon.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 19 56 , to May , 19 58 , that I last saw the deceased alive on May 22 , 19 58 , and that death occurred at 7:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Raymond M. Yow M.D.		ADDRESS (Street, city or town, state) 707 Camden, Salisbury, Md DATE SIGNED 7-8-58	
PHYSICIAN'S NAME (Type) Raymond M. Yow, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1958	
22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frempton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JUL 14 '58	
24b. REGISTRAR'S SIGNATURE W. J. Esch			

CERTIFICATE OF DEATH

1921

Page 1010

NAME OF DECEASED JOHN J. HARRIS SEX MALE AGE 45 YEARS

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 10-10-1876 PLACE OF BIRTH NEW YORK

DATE OF DEATH 10-10-1921 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

7422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 135 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Williamsburg 09x-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Darcy Middle William Last Coulbourne		4. DATE OF DEATH		Month June Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 20, 1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canning Factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Coulbourne				14. MOTHER'S MAIDEN NAME Cecilia Hurlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-6118		17. INFORMANT Hospital Records, Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infiltrating sarcoma of bladder wall 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 7 months ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20 , 19 58 , to June 4 , 19 58 , that I last saw the deceased alive on June 4 , 19 58 , and that death occurred at 6:40A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/4/58			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				ADDRESS Salisbury, Maryland Deer's Head State Hospital 6/4/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE Alf. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

Reg. Dist. No.

7423

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X White Haven</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wicomico River</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Calvert Craig Covington</u>		4. DATE OF DEATH Month Day Year <u>6-11-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/39</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>3 16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Calvert Covington</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Robertson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Calvert Covington, White Haven, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. (c) <u>—</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wading in river and stepped off into deep water.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>3:15 P.M. 6-11-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wicomico River</u>	20f. (City or town) (County) (State) <u>White Haven</u> <u>Wicomico</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <u>6-13-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gyaze Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Mount Vernon</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cornelius J. Messick, Revolve, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1483

PLACE OF BIRTH
(County)

RESIDENCE

EDUCATION

SEX

DATE OF BIRTH

AGE
AT DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

DETAILS

REMARKS

SIGNATURE

DATE

PLACE

TIME

CAUSE

INTERMEDIATE

FINAL

OTHER

DETAILS

REMARKS

SIGNATURE

DATE

PLACE

TIME

CAUSE

INTERMEDIATE

FINAL

OTHER

DETAILS

REMARKS

SIGNATURE

DATE

PLACE

TIME

CAUSE

INTERMEDIATE

FINAL

OTHER

DETAILS

REMARKS

7378

CERTIFICATE OF DEATH

07378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>PARSONSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		1 d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy DAISEY</u>		4. DATE OF DEATH <u>JUNE 24, 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23, 1958</u>
9. AGE (In years last birthday) yrs. <u>10</u> Min. <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY <u>med.</u>		11. BIRTHPLACE (State or foreign country) <u>21. S.</u>	
13. FATHER'S NAME <u>MANFORD THOMAS DAISEY</u>		14. MOTHER'S MAIDEN NAME <u>AGNES LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Manford Daisey - Parsonsburg Md.</u>	
17. INFORMANT <u>Manford Daisey - Parsonsburg Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO <u>Prematurity (Birth wt 1600 gms.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>11 hours</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/23</u> 19 <u>58</u> , to <u>6/24</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/24</u> 19 <u>58</u> , and that death occurred at <u>8:07 AM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kelli</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>6/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/25/58</u>	<u>Mechanics Cemetery</u>	<u>Millsboro - Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James - Millsboro - Del.</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 30 '58</u>		<u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082325XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07379

7379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Wicomico St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LLOYD BENJAMIN DENNIS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 25 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1902</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>3 22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy</u>	
11. BIRTHPLACE (State or foreign country) <u>Delmar, Delaware (Rural)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Algia J. Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Elizabeth Twiford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Dorothy G. Dennis (Wife)</u> Address <u>Ocean City, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary Emphysema</u> DUE TO <u>527.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , to <u>1958</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>58</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. R. Ellis Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-25-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr</u>		<u>Medical Center-Salisbury, Md.</u> <u>Jun. 25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>Alb. Smith</u> 24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>	
DATE <u>JUN 27 '58</u>			

7380

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY 2342.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>208 SEVENTH ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>W.</u> Last <u>DRYDEN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOSHUA D. DRYDEN</u>				14. MOTHER'S MAIDEN NAME <u>VANDELIA ANDREWS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>213-01-9110</u>		17. INFORMANT Address <u>MRS CATHERINE S. DRYDEN, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150x Post-operative Hemorrhage</u> DUE TO <u>Separation of suture line</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ed of esophagus</u> DUE TO (c) <u>Ed of esophagus</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6.17</u> , 19 <u>58</u> , to <u>6.18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6.18</u> , 19 <u>58</u> , and that death occurred at <u>4:47</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6/19/58</u>							
ACTUAL SIGNATURE <u>John H. Watson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Watson</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 516 E. Isabella St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle WINFIELD Last DUNN				4. DATE OF DEATH Month JUNE Day 5th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1917	9. AGE (In years last birthday) yrs. 40	IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook- Employee of Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Bivalve, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel L. Dunn				14. MOTHER'S MAIDEN NAME Grace L. Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Pauline A. Dunn (Wife) 516 E. Isabella St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Purulent Trachea Bronchitis DUE TO Acute Dilatation of Rt Atrium & Ventricles Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Cardiac Hypertrophy - Atherosclerotic heart Disease DUE TO Cardiac Hypertrophy - Atherosclerotic heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 500x							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/21 , 19 58 , to 6/6 , 19 58 , that I last saw the deceased alive on 6/6 , 19 58 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Andrew C. Mitchell Maryland Ave. Salisbury, Md Jun. 7/58							
ACTUAL SIGNATURE Dr. Andrew C. Mitchell M.D.							
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell Maryland Ave. Salisbury, Md Jun. 7/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-		22b. DATE THEREOF Jun. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE Dr. Andrew C. Mitchell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7424

CERTIFICATE OF DEATH

Reg. Dist. No.

07382

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Daisey Lee Nursing Home				d. STREET ADDRESS R.D.# 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELLEN Last ELSEY				4. DATE OF DEATH Month JUNE Day 8 th Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2, 1872	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 6 Days 8		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Portsville, Delaware	
						12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lewis Cass Elzey				14. MOTHER'S MAIDEN NAME Emily Pollitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 			
				17. INFORMANT Mr. William P. Elzey (Half-Brother) 2542 Penna Ave. Baltimore 17, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 St. Louis, Missouri DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 58 , to 6/8 , 19 58 , that I last saw the deceased alive on 6/7 , 19 58 , and that death occurred at 4:45 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE H. R. Gramse				ADDRESS (Street, city or town, state) Salisbury, Md.		DATE SIGNED June 9 1958	
PHYSICIAN'S NAME (Type) Dr. Fred Gramse				S. Division St. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 11/58		22c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE Carroll			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7382

CERTIFICATE OF DEATH

07383

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i> <i>2342.2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>1312 Princes Anne Lane.</i>	
3. NAME OF DECEASED (Type or print) <i>Mark Steven Farr</i> First Middle Last		4. DATE OF DEATH <i>June 21 1958</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 30, 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>21</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>21</i> Hours Min.
11. BIRTHPLACE (State or foreign country) <i>P.G. Hospt. Salisbury, Maryland, U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Sterling J. Farr.</i>		14. MOTHER'S MAIDEN NAME <i>Jerry Morrow.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Sterling J. Farr (Father,)</i>		1312 Princes Anne Lane. Pocomoke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Edema - marked.</i> DUE TO <i>773.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypoxic Cerebral damage in Perinatal Period</i> DUE TO <i>Prematurity (Birth wt 2 lbs - 3 oz).</i> (c) <i>82 Days</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/30</i> 19 <i>58</i> , to <i>6/21</i> 19 <i>58</i> , that I last saw the deceased alive on <i>6/21</i> 19 <i>58</i> , and that death occurred at <i>10:17</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Alfred C. Koller</i> M.D.		ADDRESS (Street, city or town, state) <i>Medical Center, Salisbury, Maryland</i> DATE SIGNED <i>6/21/58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	22b. DATE THEREOF <i>June 25, 58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Elmwood Cemetery.</i>	22d. LOCATION (City, town, or county) (State) <i>Birmingham, Ala.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Holloway & Company, Salisbury, Maryland</i> ADDRESS		24. REC'D BY REGISTRAR <i>Q. K. Koller</i> DATE <i>JUN 24 58</i>	

CERTIFICATE OF DEATH

REG. NO. 101

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESSES: [illegible]

General - [illegible]
[illegible]
[illegible] (Date of death - 10-2-20)
[illegible]

10/30/20
10/31/20
11/1/20
[illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 will be 231 7-3-58 et

07385

7425

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wilcomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 yrs. 10 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue 20X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS P.O. Box 53		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Gibson				4. DATE OF DEATH Month June Day 19 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1883	
9. AGE (In years last birthday) 74 7/2 yrs.		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) --		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME *				14. MOTHER'S MAIDEN NAME --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 217-09-3273A		17. INFORMANT Deer's Head Hospital, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -- 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1952 , to June 19, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/20/58 ACTUAL SIGNATURE V. Juerman M.D. PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58		22c. NAME OF CEMETERY OR CREMATORY Richards Cem		22d. LOCATION (City, town, or county) (State) Easton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. ...				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
				24b. REGISTRAR'S SIGNATURE ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7383

Item 8 711-2230 6-21-58 et

CERTIFICATE OF DEATH

07386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2342.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 500 Young St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Timothy Middle Gillett Last Billet				4. DATE OF DEATH Month June Day 17 Year 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1916 MAY 10, 1896	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gillett				14. MOTHER'S MAIDEN NAME Estelle Fosque			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Ethel Mason - Accomac, Va.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-7-1958 to 6-17-1958 , that I last saw the deceased alive on 6-17-1958 , and that death occurred at 11:08 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Eugene J. Linberg M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-22-58		22c. NAME OF CEMETERY OR CREMATORY Accomac		22d. LOCATION (City, town, or county) (State) Accomac VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va. ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 19 '58		24b. REGISTRAR'S SIGNATURE W. L. Beach	

CERTIFICATE OF DEATH

1923

DATE OF DEATH

December 15

11/15/23

DECEASED

John Miller

65 years old

Residence - General Hospital

800 Broadway St.

11/11

Interred

MAY 15 1924

John Miller

LABORER

Virginia

Estelle Foster

John Miller

no

John Miller - December 15

ACMWA 14

Bureau 6-55-22 Accmwa

John Miller - General Hospital, Va.

7384

CERTIFICATE OF DEATH

Reg. Dist. No.

07387

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>Gravenor</u> Last <u>Gravenor</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>BENJAMIN GRAVENOR</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH RUSSELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILLIE ENGLISH - MARDELA</u>		Address <u>MARDELA</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ischemic</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>5-15-58</u> , to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>6-2-58</u> , and that death occurred at <u>8:05 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Salisbury, MD</u>				DATE SIGNED <u>6-2-58</u>			
ACTUAL SIGNATURE <u>Willie B. Ellis Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>		22d. LOCATION (City, town, or county) (State) <u>MARDELA - MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marvel, Shafter, Md.</u>				24a. REC'D BY REGISTRAR <u>June 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quelch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 12

Age

10/10/1910

10/10/1910

10/10/1910

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10/10/1910

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10/10/1910

7388 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				d. STREET ADDRESS R.D.# (Athol Road)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle MILTON Last HARRISON				4. DATE OF DEATH Month JUNE Day 8 th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jun. 28, 1893		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper-Road Construction			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George W. Harrison				14. MOTHER'S MAIDEN NAME Carrie M. Thornton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Etta G. Harrison (Wife) R.D.# (Athol Rd Mardela, Maryland)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale, Chronic DUE TO (c) Chronic Bronchitis; Bronchiectasis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable Pulmonary Tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED June 9 / 58			
PHYSICIAN'S NAME (Type) Dr. David Gilmore M.D. Medical Center-Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 11 / 58		22c. NAME OF CEMETERY OR CREMATORY Mardela, Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The undersigned
 do hereby certify
 that the within
 is a true and
 correct copy of
 the original
 as the same
 appears in the
 records of the
 Court.

Attest my hand
 and the seal of
 the Court this
 10th day of
 March, 1901.

J. H. [Signature]
 Clerk of the Court

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07389

7386
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William J. Hastings				4. DATE OF DEATH Month June Day 11 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) BERLIN MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM J. HASTINGS JR				14. MOTHER'S MAIDEN NAME MARTHA ANNIE DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT Address MR. NORMAN HASTINGS OCEAN CITY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 25, 1958 , to 6-11 , 19 58 , that I last saw the deceased alive on 6-10 , 19 58 , and that death occurred at 5 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 6-11-58			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM		22d. LOCATION (City, town, or county) (State) BERLIN MD	
23. FUNERAL DIRECTOR'S SIGNATURE Norman H. Burboye ADDRESS Berlin Md.				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE Deborah	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Taylor</i>		AGE <i>72</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>May 21 1910</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
TIME OF DEATH <i>10:10 A.M.</i>		CAUSE OF DEATH <i>Heart failure</i>		DISEASE OR INJURY <i>Coronary artery disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>John A. Taylor</i>		SIGNATURE OF WITNESS <i>John A. Taylor</i>		SIGNATURE OF DECEASED <i>John A. Taylor</i>		SIGNATURE OF NEXT OF KIN <i>John A. Taylor</i>	
DATE OF SIGNATURE <i>May 21 1910</i>		DATE OF SIGNATURE <i>May 21 1910</i>		DATE OF SIGNATURE <i>May 21 1910</i>		DATE OF SIGNATURE <i>May 21 1910</i>	

RECEIVED
MAY 21 1910
BALTIMORE

7426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalve</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>15</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George P. Heath</u> First Middle Last				4. DATE OF DEATH <u>June 9</u> Month Day Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/2/67</u>	
9. AGE (In years and birthday) <u>91</u> yrs.		IF UNDER 1 YEAR <u>0</u> Months <u>7</u> Days		IF UNDER 24 HRS. <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Thomas Heath</u>				14. MOTHER'S MAIDEN NAME <u>Susan Russell White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Miss Naomi Heath, Jesterville, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Disease</u> <u>24 hours</u> (c) <u>Arterio sclerotic Heart Disease</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 July 1949</u> to <u>9 June 1958</u> that I last saw the deceased alive on <u>9 June 1958</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <u>Nanticoke, Md.</u> DATE SIGNED <u>6/9/58</u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				PHYSICIAN'S NAME (Type) <u>Richard H. Saunders Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jesterville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Caroline L. Messick, Bivalve, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>June 17 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Richard H. Saunders</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

1. NAME OF DECEASED [Handwritten: JAMES H. [illegible]]		2. SEX [Handwritten: Male]	
3. AGE [Handwritten: 45]		4. RACE [Handwritten: White]	
5. DATE OF BIRTH [Handwritten: 1880]		6. PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
7. DATE OF DEATH [Handwritten: 1925]		8. PLACE OF DEATH [Handwritten: Baltimore, Md.]	
9. CAUSE OF DEATH [Handwritten: Heart Disease]		10. MANNER OF DEATH [Handwritten: Natural]	
11. SIGNATURE OF PHYSICIAN [Handwritten: J. H. [illegible]]		12. SIGNATURE OF REGISTRAR [Handwritten: J. H. [illegible]]	
13. SIGNATURE OF WITNESS [Handwritten: J. H. [illegible]]		14. SIGNATURE OF WITNESS [Handwritten: J. H. [illegible]]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07391

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b X Delmar		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 3				d. STREET ADDRESS R.D.# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle DANIEL Last HILL				4. DATE OF DEATH Month JUNE Day 6 th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1900		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D.# Laurel Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elijah Emory Hill				14. MOTHER'S MAIDEN NAME Elizabeth Plummer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Bolen (Sister) R.D.# 3 Delmar Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL, etc. (Type) Burial		22b. DATE THEREOF Jun. 9, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 10 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Medical Examiner: _____

10. Signature of Coroner: _____

11. Signature of Physician: _____

12. Signature of Nurse: _____

13. Signature of Pathologist: _____

14. Signature of Forensic Scientist: _____

15. Signature of Toxicologist: _____

16. Signature of Radiologist: _____

17. Signature of Psychiatrist: _____

18. Signature of Social Worker: _____

19. Signature of Chaplain: _____

20. Signature of Funeral Home: _____

21. Signature of Cemetery: _____

22. Signature of Burial: _____

23. Signature of Interment: _____

24. Signature of Final Disposition: _____

25. Signature of Final Resting Place: _____

26. Signature of Final Burial: _____

27. Signature of Final Interment: _____

28. Signature of Final Disposition: _____

29. Signature of Final Resting Place: _____

30. Signature of Final Burial: _____

31. Signature of Final Interment: _____

32. Signature of Final Disposition: _____

33. Signature of Final Resting Place: _____

34. Signature of Final Burial: _____

35. Signature of Final Interment: _____

36. Signature of Final Disposition: _____

37. Signature of Final Resting Place: _____

38. Signature of Final Burial: _____

39. Signature of Final Interment: _____

40. Signature of Final Disposition: _____

41. Signature of Final Resting Place: _____

42. Signature of Final Burial: _____

43. Signature of Final Interment: _____

44. Signature of Final Disposition: _____

45. Signature of Final Resting Place: _____

46. Signature of Final Burial: _____

47. Signature of Final Interment: _____

48. Signature of Final Disposition: _____

49. Signature of Final Resting Place: _____

50. Signature of Final Burial: _____

51. Signature of Final Interment: _____

52. Signature of Final Disposition: _____

53. Signature of Final Resting Place: _____

54. Signature of Final Burial: _____

55. Signature of Final Interment: _____

56. Signature of Final Disposition: _____

57. Signature of Final Resting Place: _____

58. Signature of Final Burial: _____

59. Signature of Final Interment: _____

60. Signature of Final Disposition: _____

61. Signature of Final Resting Place: _____

62. Signature of Final Burial: _____

63. Signature of Final Interment: _____

64. Signature of Final Disposition: _____

65. Signature of Final Resting Place: _____

66. Signature of Final Burial: _____

67. Signature of Final Interment: _____

68. Signature of Final Disposition: _____

69. Signature of Final Resting Place: _____

70. Signature of Final Burial: _____

71. Signature of Final Interment: _____

72. Signature of Final Disposition: _____

73. Signature of Final Resting Place: _____

74. Signature of Final Burial: _____

75. Signature of Final Interment: _____

76. Signature of Final Disposition: _____

77. Signature of Final Resting Place: _____

78. Signature of Final Burial: _____

79. Signature of Final Interment: _____

80. Signature of Final Disposition: _____

81. Signature of Final Resting Place: _____

82. Signature of Final Burial: _____

83. Signature of Final Interment: _____

84. Signature of Final Disposition: _____

85. Signature of Final Resting Place: _____

86. Signature of Final Burial: _____

87. Signature of Final Interment: _____

88. Signature of Final Disposition: _____

89. Signature of Final Resting Place: _____

90. Signature of Final Burial: _____

91. Signature of Final Interment: _____

92. Signature of Final Disposition: _____

93. Signature of Final Resting Place: _____

94. Signature of Final Burial: _____

95. Signature of Final Interment: _____

96. Signature of Final Disposition: _____

97. Signature of Final Resting Place: _____

98. Signature of Final Burial: _____

99. Signature of Final Interment: _____

100. Signature of Final Disposition: _____

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen Gen. Hospital		d. STREET ADDRESS 838 Brown St	
3. NAME OF DECEASED (Type or print) WILLIAM WANNER HILL		4. DATE OF DEATH JUNE 9 th 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1955
9. AGE (in years last birthday) 2 yrs.		10. IF UNDER 1 YEAR 7 Months 4 Days 4 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William W. Hill Sr		14. MOTHER'S MAIDEN NAME Mabel M. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. William W. Hill (Father)		Address 838 Brown St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 813X FRACTURED SKULL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Child fell from bicycle under truck DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 2:30 a.m. 6 9 19 58 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Brown St		20f. (City or town) Salisbury (County) Wicomico (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED June 10 1958	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) Salisbury, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 13 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7388

CERTIFICATE OF DEATH

07393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>FAIRMOUNT</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>198-2</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First Middle Last <u>HOFFMAN</u>				4. DATE OF DEATH <u>JUNE 4,</u> Month Day Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 17, 1900</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARTIN, W. VA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ERNEST MICHAEL</u>			14. MOTHER'S MAIDEN NAME <u>ETTA BURGESS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. THOMAS PARKS - FAIRMOUNT, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.1</u> DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> DUE TO <u>Coronary Atherosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>approx. 2 yrs.</u> <u>" 3 yrs.</u> <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Hepato-renal Failure</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>SALISBURY, MD.</u>			
21. I certify that I attended the deceased from <u>JUNE 4,</u> 19 <u>58</u> , to <u>15</u> , 19 <u>58</u> , that I last saw the deceased <u>olive on</u> <u>JUNE 4,</u> 19 <u>58</u> , and that death occurred at <u>10 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>SALISBURY, MD.</u>		DATE SIGNED <u>6/4/58</u>			
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE, M.D.</u>		<u>SALISBURY, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRMOUNT, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW-SONS-</u> ADDRESS <u>CRISFIELD, MD.</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deedman</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07394

7389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i> <i>23422</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsular General Hospital</i>		d. STREET ADDRESS <i>413 Oxford St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Eben Holden</i>		4. DATE OF DEATH Month Day Year <i>June 3- 1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4 1958</i>	9. AGE (In years last birthday) yrs. <i>37</i> Months Days Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>James Holden</i>		14. MOTHER'S MAIDEN NAME <i>Etha Robinson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Holden</i> Address <i>413 Oxford St. Pocomoke md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.0</i> DUE TO <i>aspiration, acute, with focal atelectasis and anoxemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>congenital bilateral hare-lip, cleft palate, absence of kidney +</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>asphyxia et anoxemia</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/2/58</i> to <i>6/3/58</i> that I last saw the deceased alive on <i>6/2/58</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>R. L. Seidman</i>		ADDRESS (Street, city or town, state) <i>707 Camden Ave. Salisbury, Md.</i>		DATE SIGNED <i>6/3/58</i>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 8, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cottage Grove, Cem.</i>	
22d. LOCATION (City, town, or county) (State) <i>Westover, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton</i>		ADDRESS <i>New Church, Va.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 9 58</i>	
24b. REGISTRAR'S SIGNATURE <i>W. Seidman</i>					

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

7428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 253 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Pocomoke 2342.2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle William Last Holland				4. DATE OF DEATH Month June Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ira Frank Holland				14. MOTHER'S MAIDEN NAME Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Hospital Records,		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Residual Right Hemiplegia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15 , 19 57 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 10:05AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital Salisbury, Maryland Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				DATE SIGNED 6/26/58 6/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-58		22c. NAME OF CEMETERY OR CREMATORY Brittinghams Cemetery		22d. LOCATION (City, town, or county) (State) Rural New Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR JUN 30 58 DATE	
24b. REGISTRAR'S SIGNATURE W. H. Leach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

1997

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

Item 18-21 Film 251 7-7-58 amg
7390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 9 Film 251 7-7-58 et

07396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic</u> <u>83X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Frederick</u> Last <u>Hudson</u>			4. DATE OF DEATH Month <u>6-</u> Day <u>18-</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15, 1953</u>		9. AGE (In years last birthday) <u>5 1/2</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Nassauadey Va</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME <u>Frederick Hudson</u>			14. MOTHER'S MAIDEN NAME <u>Helilah Taylor</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Leonard Taylor</u> Address <u>Horsey Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-arachnoid hemorrhage</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell and hurt head in tussle with another child.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6-</u> a. m. <u>17-</u> p. m. <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Atlantic</u>		20g. (County) <u>Accomack</u>		20h. (State) <u>Va.</u>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shownings</u>	
22d. LOCATION (City, town, or county) <u>Wak. Hall</u>		22e. (State) <u>Va.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u>	
23a. ADDRESS <u>Parkley, Va</u>		24a. REC'D BY REGISTRAR <u>JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Earl L Royer</u>	

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1

2

88

2

FOR STATE
HEALTH DEPT.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: John Doe

2. AGE: 45 YEARS

3. SEX: Male

4. RACE: White

5. OCCUPATION: Teacher

6. PLACE OF BIRTH: New York City

7. DATE OF DEATH: 1945-10-15

8. TIME OF DEATH: 10:30 AM

9. PLACE OF DEATH: Home

10. CAUSE OF DEATH: Myocardial Infarction

11. MANNER OF DEATH: Natural

12. SIGNATURE OF EXAMINER: [Signature]

13. TITLE OF EXAMINER: Medical Examiner

14. ADDRESS OF EXAMINER: 123 Main St, New York City

15. DATE OF EXAMINATION: 1945-10-16

16. SIGNATURE OF WITNESS: [Signature]

17. TITLE OF WITNESS: Physician

18. ADDRESS OF WITNESS: 456 Main St, New York City

19. DATE OF WITNESS: 1945-10-16

20. SIGNATURE OF CORONER: [Signature]

21. TITLE OF CORONER: Coroner

22. ADDRESS OF CORONER: 789 Main St, New York City

23. DATE OF CORONER: 1945-10-16

7391

CERTIFICATE OF DEATH

Reg. Dist. No.

07397

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE N Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague 83x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 56 W. Kearsarge Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FRED Last HULL		4. DATE OF DEATH Month June Day 12 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jun. 10, 1958
9. AGE (In years last birthday) yrs. 0		IF UNDER 1 YEAR: Months 0 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Chincoteague Air Station Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred Albron Hull		14. MOTHER'S MAIDEN NAME Helen Lamp Cheek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Lt. Fred A. Hull (Father)		Address 56 W. Kearsarge Circle - Chincoteague, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 Intestinal Volvulus and obstruction 1 day DUE TO Torsion of Small Bowel (Pyloric) 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diaphragmatic Hernia with the placenta DUE TO of entire abdominal viscera into chest 1 1/2 days (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhage of adrenals and kidneys; atelectasis of lungs INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from June 10, 1958 to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED June 13, 1958			
ACTUAL SIGNATURE R. W. Saunderson Jr. M.D.		DATE SIGNED June 13, 1958	
PHYSICIAN'S NAME (Type) Dr. Robert W. Saunderson Jr. Camden Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 14, 1958	Cabarrus Memorial Cem.	Concord, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7392

CERTIFICATE OF DEATH

07398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>31 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Penna SWLA General Hospital</u>				e. STREET ADDRESS <u>Camden Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Helen</u> First Middle Last				4. DATE OF DEATH <u>June</u> Month <u>22</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas M. Jamart</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Wilhelm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-38-0084</u>		17. INFORMANT <u>Grace S Smith</u> Address <u>606 Hollen Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema, acute</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Edema</u> DUE TO (c) <u>Edema</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Edema</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/18</u> 19 <u>58</u> , to <u>6/22</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/22</u> 19 <u>58</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>6-23-58</u>							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type) <u>William R. Ellis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & SONS Co.</u> ADDRESS <u>4905 YORK RD.</u>				24a. REC'D BY REGISTRAR <u>JUN 26 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

1922

1. NAME OF DECEASED JAMES H. LITTLE		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15 1877		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Clerk		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. TIME OF DEATH 10:30 AM	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF CLERK J. H. Smith		13. SIGNATURE OF WITNESS J. H. Smith		14. SIGNATURE OF DECEASED J. H. Smith		15. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
16. SIGNATURE OF REGISTRAR J. H. Smith		17. SIGNATURE OF CLERK J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF DECEASED J. H. Smith		20. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
21. SIGNATURE OF REGISTRAR J. H. Smith		22. SIGNATURE OF CLERK J. H. Smith		23. SIGNATURE OF WITNESS J. H. Smith		24. SIGNATURE OF DECEASED J. H. Smith		25. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
26. SIGNATURE OF REGISTRAR J. H. Smith		27. SIGNATURE OF CLERK J. H. Smith		28. SIGNATURE OF WITNESS J. H. Smith		29. SIGNATURE OF DECEASED J. H. Smith		30. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
31. SIGNATURE OF REGISTRAR J. H. Smith		32. SIGNATURE OF CLERK J. H. Smith		33. SIGNATURE OF WITNESS J. H. Smith		34. SIGNATURE OF DECEASED J. H. Smith		35. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
36. SIGNATURE OF REGISTRAR J. H. Smith		37. SIGNATURE OF CLERK J. H. Smith		38. SIGNATURE OF WITNESS J. H. Smith		39. SIGNATURE OF DECEASED J. H. Smith		40. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
41. SIGNATURE OF REGISTRAR J. H. Smith		42. SIGNATURE OF CLERK J. H. Smith		43. SIGNATURE OF WITNESS J. H. Smith		44. SIGNATURE OF DECEASED J. H. Smith		45. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
46. SIGNATURE OF REGISTRAR J. H. Smith		47. SIGNATURE OF CLERK J. H. Smith		48. SIGNATURE OF WITNESS J. H. Smith		49. SIGNATURE OF DECEASED J. H. Smith		50. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
51. SIGNATURE OF REGISTRAR J. H. Smith		52. SIGNATURE OF CLERK J. H. Smith		53. SIGNATURE OF WITNESS J. H. Smith		54. SIGNATURE OF DECEASED J. H. Smith		55. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
56. SIGNATURE OF REGISTRAR J. H. Smith		57. SIGNATURE OF CLERK J. H. Smith		58. SIGNATURE OF WITNESS J. H. Smith		59. SIGNATURE OF DECEASED J. H. Smith		60. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
61. SIGNATURE OF REGISTRAR J. H. Smith		62. SIGNATURE OF CLERK J. H. Smith		63. SIGNATURE OF WITNESS J. H. Smith		64. SIGNATURE OF DECEASED J. H. Smith		65. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
66. SIGNATURE OF REGISTRAR J. H. Smith		67. SIGNATURE OF CLERK J. H. Smith		68. SIGNATURE OF WITNESS J. H. Smith		69. SIGNATURE OF DECEASED J. H. Smith		70. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
71. SIGNATURE OF REGISTRAR J. H. Smith		72. SIGNATURE OF CLERK J. H. Smith		73. SIGNATURE OF WITNESS J. H. Smith		74. SIGNATURE OF DECEASED J. H. Smith		75. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
76. SIGNATURE OF REGISTRAR J. H. Smith		77. SIGNATURE OF CLERK J. H. Smith		78. SIGNATURE OF WITNESS J. H. Smith		79. SIGNATURE OF DECEASED J. H. Smith		80. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
81. SIGNATURE OF REGISTRAR J. H. Smith		82. SIGNATURE OF CLERK J. H. Smith		83. SIGNATURE OF WITNESS J. H. Smith		84. SIGNATURE OF DECEASED J. H. Smith		85. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
86. SIGNATURE OF REGISTRAR J. H. Smith		87. SIGNATURE OF CLERK J. H. Smith		88. SIGNATURE OF WITNESS J. H. Smith		89. SIGNATURE OF DECEASED J. H. Smith		90. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
91. SIGNATURE OF REGISTRAR J. H. Smith		92. SIGNATURE OF CLERK J. H. Smith		93. SIGNATURE OF WITNESS J. H. Smith		94. SIGNATURE OF DECEASED J. H. Smith		95. SIGNATURE OF NEAREST RELATIVE J. H. Smith	
96. SIGNATURE OF REGISTRAR J. H. Smith		97. SIGNATURE OF CLERK J. H. Smith		98. SIGNATURE OF WITNESS J. H. Smith		99. SIGNATURE OF DECEASED J. H. Smith		100. SIGNATURE OF NEAREST RELATIVE J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07399

7393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> 1939.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>BROADWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>—</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CRAB + OYSTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>EDWIN JONES</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>231-12-3950</u>		17. INFORMANT Address <u>VIRGINIA STERLING, CRISFIELD, MO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u> DUE TO (b) <u>150x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>58</u> , to <u>10:00 PM</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>58</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SALISBURY, MD.</u> DATE SIGNED <u>Eugene J. Linberg</u>							
ACTUAL SIGNATURE <u>Eugene J. Linberg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EUGENE J. LINBERG</u> <u>SALISBURY, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAWSONIA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MO.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. HARVEY BRADSHAW, MARYLAND</u> ADDRESS <u>CRISFIELD, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CÉRTIFICATE OF DEATH

Reg. Dist. No.

07400

7394

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Salisbury (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>				d. STREET ADDRESS <u>Mt. Hermon Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>DALE</u> Last <u>KELLEY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 31, 1887</u>	
9. AGE (in years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>27</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Willards, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>James K. Patey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Margaret Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Harry V. Jones (Daughter)</u>				Address <u>225 Glen Ave Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Atherosclerotic cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>Year</u> <u>Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1:18 P.M.</u> 19 <u>58</u> , to <u>6/28</u> 19 <u>58</u> , that I last saw the deceased alive on <u>1:18 P.M. 6/28/58</u> , and that death occurred at <u>1:18 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Maryland Ave. Salisbury, Md</u> DATE SIGNED <u>Jun. 28, 1958</u>							
ACTUAL SIGNATURE <u>Dr. O. J. Burton</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. O. J. Burton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jun. 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle John Last Kohn		4. DATE OF DEATH Month June Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71	IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Kohn		14. MOTHER'S MAIDEN NAME Sophia Losand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Helen Watson, Mardela Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Don't know DUE TO (c) Don't know		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no more		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1958 , to June 19, 1958 , that I lost saw the deceased olive on June 15, 1958 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mardela Springs DATE SIGNED June 19, 1958			
ACTUAL SIGNATURE Fred C. Quinn M.D.		DATE SIGNED June 19, 1958	
PHYSICIAN'S NAME (Type) FRED C. QUINN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-22-58	22c. NAME OF CEMETERY OR CREMATORY Mardela	22d. LOCATION (City, town, or county) (State) Mardela Springs
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gamel, M.D.		24. REC'D BY REGISTRAR W. H. 23 58	
ADDRESS		25. REGISTRAR'S SIGNATURE W. H. 23 58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Keywords: *correlates, caregivers, caregivers, parents, fathers, mothers, children, children, children*

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7395

CERTIFICATE OF DEATH

07402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN TB <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>530 WASHINGTON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOVELLA</u> Middle <u>MARSH</u> Last <u>MARSH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>TYLERTON, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES T. EVANS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BRADSHAW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>ERVIN C. MARSH - 530 WASHINGTON ST. - MARYLAND</u>		Address <u>SALISBURY,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1952</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>58</u> , and that death occurred at <u>10:05</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alberta Mattax</u> M.D.		ADDRESS (Street, city or town, state) <u>711 CAIDEN ST. - SALISBURY, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>ALBERTA MATTAX, M.D.</u>		DATE SIGNED <u>6/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 23, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SUNNYRIDGE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS - CRISFIELD, MD.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

1933

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
John J. Smith		45		Male		White		Jan 15, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		123 Main St.		J. J. Smith		J. J. Smith	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Mary J. Brown		60		Female		White		Jan 16, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		456 Elm St.		M. J. Brown		M. J. Brown	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Robert L. Green		35		Male		White		Jan 17, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		789 Oak St.		R. L. Green		R. L. Green	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Elizabeth A. White		55		Female		White		Jan 18, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		101 Pine St.		E. A. White		E. A. White	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
William H. Black		40		Male		White		Jan 19, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		234 Cedar St.		W. H. Black		W. H. Black	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Margaret K. Taylor		50		Female		White		Jan 20, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		567 Birch St.		M. K. Taylor		M. K. Taylor	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
James P. Miller		30		Male		White		Jan 21, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		890 Spruce St.		J. P. Miller		J. P. Miller	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Anna M. Davis		45		Female		White		Jan 22, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		123 Maple St.		A. M. Davis		A. M. Davis	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Charles E. Wilson		35		Male		White		Jan 23, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		456 Elm St.		C. E. Wilson		C. E. Wilson	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Helen L. Moore		55		Female		White		Jan 24, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		789 Oak St.		H. L. Moore		H. L. Moore	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Frank J. Adams		40		Male		White		Jan 25, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		101 Pine St.		F. J. Adams		F. J. Adams	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Grace B. Clark		50		Female		White		Jan 26, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		234 Cedar St.		G. B. Clark		G. B. Clark	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Edward G. Lewis		30		Male		White		Jan 27, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		567 Birch St.		E. G. Lewis		E. G. Lewis	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Bertha C. Hall		45		Female		White		Jan 28, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		890 Spruce St.		B. C. Hall		B. C. Hall	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
George W. Young		35		Male		White		Jan 29, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		123 Maple St.		G. W. Young		G. W. Young	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Alice M. King		55		Female		White		Jan 30, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		456 Elm St.		A. M. King		A. M. King	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Harold N. Scott		40		Male		White		Jan 31, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		789 Oak St.		H. N. Scott		H. N. Scott	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Lillian P. Green		50		Female		White		Feb 1, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		101 Pine St.		L. P. Green		L. P. Green	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Roy L. Baker		30		Male		White		Feb 2, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		234 Cedar St.		R. L. Baker		R. L. Baker	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Dorothy E. Nelson		45		Female		White		Feb 3, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		567 Birch St.		D. E. Nelson		D. E. Nelson	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Walter H. Phillips		35		Male		White		Feb 4, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		890 Spruce St.		W. H. Phillips		W. H. Phillips	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Evelyn K. Wright		55		Female		White		Feb 5, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		123 Maple St.		E. K. Wright		E. K. Wright	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Clarence J. Reed		40		Male		White		Feb 6, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		456 Elm St.		C. J. Reed		C. J. Reed	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Beatrice L. Cook		50		Female		White		Feb 7, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		789 Oak St.		B. L. Cook		B. L. Cook	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Arthur M. Bell		30		Male		White		Feb 8, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		101 Pine St.		A. M. Bell		A. M. Bell	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Mildred A. Evans		45		Female		White		Feb 9, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		234 Cedar St.		M. A. Evans		M. A. Evans	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Royce W. Foster		35		Male		White		Feb 10, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		567 Birch St.		R. W. Foster		R. W. Foster	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Norma J. Hill		55		Female		White		Feb 11, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		890 Spruce St.		N. J. Hill		N. J. Hill	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Lester B. James		40		Male		White		Feb 12, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		123 Maple St.		L. B. James		L. B. James	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Gladys C. Miller		50		Female		White		Feb 13, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		456 Elm St.		G. C. Miller		G. C. Miller	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Harold E. Taylor		30		Male		White		Feb 14, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		789 Oak St.		H. E. Taylor		H. E. Taylor	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Bertha M. Young		45		Female		White		Feb 15, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		101 Pine St.		B. M. Young		B. M. Young	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Clarence F. Green		35		Male		White		Feb 16, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		234 Cedar St.		C. F. Green		C. F. Green	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Dorothy L. White		55		Female		White		Feb 17, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		567 Birch St.		D. L. White		D. L. White	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Walter N. Black		40		Male		White		Feb 18, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		890 Spruce St.		W. N. Black		W. N. Black	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Evelyn K. Brown		50		Female		White		Feb 19, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		123 Maple St.		E. K. Brown		E. K. Brown	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Royce W. Taylor		30		Male		White		Feb 20, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		456 Elm St.		R. W. Taylor		R. W. Taylor	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Beatrice L. Green		45		Female		White		Feb 21, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		789 Oak St.		B. L. Green		B. L. Green	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Harold E. White		35		Male		White		Feb 22, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Carpenter		101 Pine St.		H. E. White		H. E. White	
Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Disease		Occupation		Residence		Signature of Physician		Signature of Registrar	
Gladys C. Miller		50		Female		White		Feb 23, 1933		Boston, Mass.		Heart Disease		Coronary Artery Sclerosis		Housewife		234 Cedar St.		G. C. Miller		G. C. Miller	

7396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 25 Yrs.				d. STREET ADDRESS 905 Register St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 905 Register St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMRA Middle LEE Last MARVEL				4. DATE OF DEATH Month 6 Day 22 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, Retired				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Marvel				14. MOTHER'S MAIDEN NAME Clara Beach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1903-06		17. INFORMANT Mrs. Emma M. Marvel, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma (Bronchogenic) of lung. (c) 4 mos INTERVAL BETWEEN ONSET AND DEATH 21 hr				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/28 , 19 58 , to 6/22 , 19 58 , that I last saw the deceased alive on 3/26 , 19 58 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 6/24/58							
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D.				PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, JR. Medical Center			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE JUN 25 1958		24b. REGISTRAR'S SIGNATURE Decker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7397
CERTIFICATE OF DEATH

07404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Massey Last Massey				4. DATE OF DEATH Month June Day 28 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-16-1875	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME W. F. Massey			
14. MOTHER'S MAIDEN NAME Melinda Phoebus				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT F.R. Stansel, 33 Elm St. Mass.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure & Atherosclerosis & Fibrillation 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Wicomico		20h. (State) Maryland	
21. I certify that I attended the deceased from January 5, 19 58 , to June 28, 19 58 , that I last saw the deceased alive on June 27, 19 58 , and that death occurred at 6:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 226 N. Division St. Salisbury, Md. DATE SIGNED _____ ACTUAL SIGNATURE Dr. Carrie I. Hearn M.D. PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury				24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

Norman T. Baker

7430

CERTIFICATE OF DEATH

Reg. Dist. No. 07405

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2				d. STREET ADDRESS R.D.# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARITA Middle MAE Last McDORMAN				4. DATE OF DEATH Month JUNE Day 4 th 19 Year 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1913	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 1 Days 29 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smyrna, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Albert F. Lewis				14. MOTHER'S MAIDEN NAME Nannie Wade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr John William McDorman (Husband)				Address R.D.#2 Eden, Maryland			
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive heart failure DUE TO mitral stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							
INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Yes.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar. 1958 to June 1958 , that I last saw the deceased alive on 6/6/58 , and that death occurred at Eden, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eden, Maryland DATE SIGNED Jun 6 / 58							
ACTUAL SIGNATURE Earl Beardsley M.D. 							
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave Salisbury, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1958		22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 10 1958	
24b. REGISTRAR'S SIGNATURE W. B. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS, COUNTY OF DALLAS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7398

CERTIFICATE OF DEATH

07406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN TB <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Simmie Lee McIntosh</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 16 - 1907</u>	
9. AGE (In years last birthday) <u>51 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales</u>		11. BIRTHPLACE (State or foreign country) <u>Vidalia, Georgia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charlie Mcintosh</u>				14. MOTHER'S MAIDEN NAME <u>Mazie Dickles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>70</u>			
17. INFORMANT <u>Mrs. Sadie McIntosh</u> Address <u>517 7th W. 16 Ave</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 445X DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertension</u> (c) <u>Malquant Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/23</u> , 19 <u>58</u> , to <u>6/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.				DATE SIGNED <u>June 23, 1958</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Zion Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Dennis</u> ADDRESS <u>Snow Hill, Md</u>				24. REC'D BY REGISTRAR <u>W. J. Search</u> DATE <u>JUN 26 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Two for one certificate
 Film 9227- 7/5/58-
 MB.

Robert L. H. H. H.
 Robert L. H. H. H.
 Robert L. H. H. H.

Robert L. H. H. H.
 Robert L. H. H. H.
 Robert L. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND—BALTIMORE, 18 7399 Items 8,9,11,12,13,14 Film G230 6-17-58 et CERTIFICATE OF DEATH										07407	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>21 DAYS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE 19X-2</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>R.R. 3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>MCINTYRE</u> Last <u>MCINTYRE</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1958</u>								
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 7, 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James R. McIntyre</u>					14. MOTHER'S MAIDEN NAME <u>Georgianna Jones</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447X</u> <u>Memoria</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Unlabeled</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>58</u> to <u>6-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-1</u> , 19 <u>58</u> , and that death occurred at <u>5:41 A.M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>W. J. Ellis</u>			M.D. <u>Salisbury, Md.</u>			ADDRESS (Street, city or town, state)			DATE SIGNED <u>6-1-58</u>		
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>			<u>6/3/58</u>		<u>St Andrews</u>			<u>Princess Anne, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hannon</u>					ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Ellis</u>		

MAILED AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07408

7400 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>MD</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place)		TOWN <i>Salisbury MD</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>D.S. Hesp</i>				STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Hewitt Richard Merritt</i>				<i>6 6 58</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>		8. DATE OF BIRTH <i>12-6-01</i>	
9. AGE last birthday <i>57</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>VA</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Charles Stondy</i>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2. IMMEDIATE CAUSE (A) <i>Leuremia</i>		3. ANTECEDENT CAUSE(S) DUE TO		4. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	
5. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		6. DATE OF OPERATION		7. MAJOR FINDINGS OF OPERATION		8. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		10. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		11. WHERE DID INJURY OCCUR? (City or town) (County) (State)		12. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
13. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		14. HOW DID INJURY OCCUR?		15. I hereby certify that I attended the deceased from <i>May 1958</i> , to <i>June 1958</i> , that I last saw the deceased alive on <i>June 1958</i> , and that death occurred at <i>10:00 A.M.</i> from the causes and on the date stated above.		16. SIGNATURE <i>W. H. H. H.</i> DATE SIGNED <i>7/10/58</i>	
17. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		18. DATE THEREOF <i>6-14-58</i>		19. NAME OF CEMETERY OR CREMATORY <i>Houston Cem.</i>		20. LOCATION (City, town, or county) <i>Salisbury MD</i>	
21. REC'D BY REGISTRAR <i>JUN 16 '58</i>		22. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Boaker McWest</i>		24. ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12 CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF BIRTH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CORONER

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7401 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN lb <u>LIFE TIME</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <u>6-</u> Day <u>17-</u> Year <u>19 58</u>	
3. NAME OF DECEASED (Type or print) <u>Donald Mills, Jr.</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9.20/56</u>		9. AGE (In years last birthday) <u>1</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAN D</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>DONALD MILLS SR.</u>		14. MOTHER'S MAIDEN NAME <u>LAURA CHENAULT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>LAURA CHENAULT. SALISBURY, MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of the brain</u> <u>351x</u> DUE TO (b) <u>Cerebral palsy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>20 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOUSE JACOB</u>		22d. LOCATION (City, town, or county) (State) <u>CHANCE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James</u> ADDRESS <u>Chesapeake</u>		24a. REC'D BY REGISTRAR <u>ONE</u> 24b. REGISTRAR'S SIGNATURE <u>ONE</u>	

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7402

CERTIFICATE OF DEATH

07410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. STREET ADDRESS 108 E. Locust St.	
3. NAME OF DECEASED (Type or print) First MILDRED Middle MAE Last MULFORD		4. DATE OF DEATH Month JUNE Day 3 rd Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Month 3 Day 12	IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Wingate, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George H. Jones		14. MOTHER'S MAIDEN NAME Elnora Ewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Mr. C. Clifton Mulford (Husband) 108 E. Locust St. Salisbury, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of lung. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of cervix DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 6/58 , to 6/3/58 , that I last saw the deceased alive on 6/3/58 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl H. Beardsley		ADDRESS (Street, city or town, state) DATE SIGNED June 4, 1958	
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jun. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JUN 9 '58		24b. REGISTRAR'S SIGNATURE Earl H. Beardsley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7403

CERTIFICATE OF DEATH

07411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> 23X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>403 MARKET ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>NELSON</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 1, 1958</u>	
9. AGE (In years last birthday) yrs. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROLLIE J. NELSON</u>				14. MOTHER'S MAIDEN NAME <u>ELLA MAE WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or if not) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rollie Nelson</u> Address <u>403 W. Market St. Snow Hill Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (Birth Wt 14 oz.)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>6/1/58</u> to <u>6/1/58</u> that I last saw the deceased alive on <u>6/1/58</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>702 Camden Ave Salisbury Md</u>			
DATE SIGNED <u>6/1/58</u>							
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Snow Hill Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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CERTIFICATE OF DEATH

1913

PLACE OF BIRTH (State, Territory, or Foreign Country) _____		SEX Male _____ Female _____	
DATE OF BIRTH (Month, Day, Year) _____		AGE (Years, Months, Days) _____	
OCCUPATION _____		CAUSE OF DEATH (Immediate Cause) _____	
PLACE OF DEATH (City, Town, or Village) _____		DATE OF DEATH (Month, Day, Year) _____	
TIME OF DEATH (Hour, Minute) _____		PLACE OF INTERMENT (City, Town, or Village) _____	
NAME OF PHYSICIAN _____		NAME OF CLERGYMAN _____	
NAME OF WITNESS _____		NAME OF REGISTRAR _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CLERGYMAN _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF REGISTRAR _____	

TO BE FILLED BY THE REGISTRAR OF DEATHS

1. Name of Deceased: _____

2. Date of Death: _____

3. Place of Death: _____

4. Cause of Death: _____

5. Name of Physician: _____

6. Name of Clergyman: _____

7. Name of Witness: _____

8. Name of Registrar: _____

9. Signature of Registrar: _____

10. Date of Filing: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07412

Reg. Dist. No.

7431

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Robert M. Nutter</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>58</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/98</u>		
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>7</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Sidney Nutter</u>				14. MOTHER'S MAIDEN NAME <u>Milich Conway</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Willie Nutter, Jesterville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Pancreas</u> DUE TO <u>Several abdominal metastases</u> (c) <u>metastatic</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <u>6-9-58</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jesterville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Corneille D. Mercier, Beltsville, Md.</u>					ADDRESS <u>Beltsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville c. LENGTH OF STAY IN 1b Most of Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 2.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS Route # 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jefferson Last Perdue		4. DATE OF DEATH Month June Day 22. Year 19 58.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20.1887. 9. AGE (In years last birthday) 71 yrs. Months 4 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Parsonsburg, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Marshall Perdue		14. MOTHER'S MAIDEN NAME Millie Parsons.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Florence Ellen Perdue, (Wife) Address Route. #2 Pittsville, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) yes DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Dr. Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 25.58.	Warren Cemetery.	Near Pittsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JUN 24 '58 24b. REGISTRAR'S SIGNATURE W. B. Search	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
EXAMINER

WEST AND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935

City of Baltimore, Maryland

1935

John Doe

1935

John Doe

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John Doe

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John Doe

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John Doe

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John Doe

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John Doe

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John Doe

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John Doe

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7404

CERTIFICATE OF DEATH

07414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>KLEJ GRANGE</u>	
3. NAME OF DECEASED (Type or print) First <u>Mariam</u> Middle <u>E.</u> Last <u>Pilchard</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17, 1891</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALONZO G. PAYNE</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE TOWNSEND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ASA F. PILCHARD</u>		Address <u>POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-13, 1958</u> to <u>6-13, 1958</u> , that I last saw the deceased alive on <u>6-13, 1958</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter Ellis, Jr.</u> M.D.		DATE SIGNED <u>6-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Walter Ellis, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GOODWILL METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL POCOMOKE CITY, M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>POCOMOKE, M.D.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07415

7405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Neomica</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salesbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 237-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Federal St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard C.</u> Middle <u>C.</u> Last <u>Poole</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12 1899</u> 58/12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gardner Poole</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rudy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or date of service) <u>W. W. I.</u>		16. SOCIAL SECURITY NO. <u>087-05-3662</u>	
17. INFORMANT <u>Richard C. Poole Jr.</u> Address <u>50 Dawsonport Ave New Rochelle N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 HR.</u> <u>5 YR.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 14</u> , 19 <u>58</u> , to <u>JUNE 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 14</u> , 19 <u>58</u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D. Bay St., Snow Hill, Md.		DATE SIGNED <u>6-16-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>June 18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Penn Cliff</u>	22d. LOCATION (City, town, or county) (State) <u>Hartsville N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman A. Morris</u> ADDRESS <u>Snow Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

MARYLAND STATE DEPARTMENT OF HEALTH-CATIMORE 18

7433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>HECOMACK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE-CITY</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ONANEOCK</u> 83X-3	
c. LENGTH OF STAY IN 1b <u>4-YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MRS. HEDDING - REST-HOME</u>		d. STREET ADDRESS <u>JUSTIS -</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENORA</u> Middle <u>ANDS</u> Last <u>RAYFIELD</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4th</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-30-1880</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>ONANEOCK-VA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U-S-A.</u>			
13. FATHER'S NAME <u>LORENZO - D. KILLMON</u>		14. MOTHER'S MAIDEN NAME <u>REUTH - H. - KILLMON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Defecia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degenerative Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, left following Cerebral Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>large</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. n.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>58</u> to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Trader, M.D.</u>		ADDRESS (Street, city or town, state) <u>307 Market St., Pocomoke City, Md.</u>	
DATE SIGNED <u>6-6-58</u>			
PHYSICIAN'S NAME (Type) <u>Charles W. Trader, M.D.</u>		<u>Pocomoke City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY MT - HOLY</u>	22d. LOCATION (City, town, or county) (State) <u>ONANEOCK-VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>FOX & KELLAM</u>		ADDRESS <u>ONANEOCK-VA</u>	
24a. REC'D BY REGISTRAR <u>SEN 10-58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07417

7406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> 231-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				e. STREET ADDRESS <u>PHILADELPHIA A.</u>			
3. NAME OF DECEASED (Type or print) First Middle (Riley) <u>Rose TILLMAN RILEY</u>				4. DATE OF DEATH Month Day Year <u>June 3, 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27, 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HENDERSON, KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE CUNNINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>ANNE HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>116</u>		17. INFORMANT Address <u>JAMES PRICE Ocean City, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>continued</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3</u> , 19 <u>58</u> , to <u>6-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-3</u> , 19 <u>58</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-9-58</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 11 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Ellis</u>	

7434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1422 Madison Avenue			
3. NAME OF DECEASED (Type or print) First Roosevelt Middle Ringgold Last Ringgold				4. DATE OF DEATH Month June Day 12 Year 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1902	
9. AGE (In years last birthday) 55		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 19 Min.		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly				10b. KIND OF BUSINESS OR INDUSTRY Hospital orderly		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Ringgold				14. MOTHER'S MAIDEN NAME Susan Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. 216-09-9474		17. INFORMANT Deer's Head Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 Gliomocerebral astroblastoma DUE TO (b) 193.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 193.0 DUE TO (c) 193.0 INTERVAL BETWEEN ONSET AND DEATH 5 1/2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 193.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958 , to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. V. Juerman				DATE SIGNED 6/12/58			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital, Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ann Arundel County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. H. Heston				24a. REC'D BY REGISTRAR June 16 '58		24b. REGISTRAR'S SIGNATURE Deer's Head	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407

CERTIFICATE OF DEATH

07419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS Mt Hermon Rd. (POB#590)	
3. NAME OF DECEASED (Type or print) JEANNE First PATRICIA Middle SAUDER Last		4. DATE OF DEATH JUNE Month 14 Day 1958 Year	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby	8. DATE OF BIRTH April 16, 1957
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Rev. Harvey L. Sauder	
14. MOTHER'S MAIDEN NAME Dorothy Lee Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Harvey Louis Sauder (Father) Address Mt. Hermon Rd. - POB#590 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalitis DUE TO Complication of Measles Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complication of Measles DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 2:30 PM	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/13/58 19 to 6/14/58 19, that I last saw the deceased alive on 6/14/58 19, and that death occurred at 6:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carrie I Hearn M.D.		ADDRESS (Street, city or town, state) 226 N. Division St DATE SIGNED 6/14/58	
PHYSICIAN'S NAME (Type) CARRIE I HEARN			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 17, 1958	22c. NAME OF CEMETERY OR CREMATORY Mansfield Cemetery	22d. LOCATION (City, town, or county) (State) Mansfield, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JUN 18 58 DATE	24b. REGISTRAR'S SIGNATURE W. Hearn

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED <i>Charles J. Hearne</i>		AGE <i>35</i>	SEX <i>Male</i>	RACE <i>White</i>	DATE OF BIRTH <i>May 15, 1868</i>	PLACE OF BIRTH <i>St. Louis, Mo.</i>	DATE OF DEATH <i>May 15, 1903</i>	PLACE OF DEATH <i>St. Louis, Mo.</i>
FATHER'S NAME <i>John H. Hearne</i>		MOTHER'S NAME <i>Elizabeth A. Hearne</i>						
OCCUPATION <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>						
PREVIOUS ILLNESS <i>None</i>		TIME OF DEATH <i>10:30 AM</i>						
SIGNATURE OF PHYSICIAN <i>Wm. H. H. H.</i>								

NAME OF DECEASED <i>Charles J. Hearne</i>		AGE <i>35</i>	SEX <i>Male</i>	RACE <i>White</i>	DATE OF BIRTH <i>May 15, 1868</i>	PLACE OF BIRTH <i>St. Louis, Mo.</i>	DATE OF DEATH <i>May 15, 1903</i>	PLACE OF DEATH <i>St. Louis, Mo.</i>
FATHER'S NAME <i>John H. Hearne</i>		MOTHER'S NAME <i>Elizabeth A. Hearne</i>						
OCCUPATION <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>						
PREVIOUS ILLNESS <i>None</i>		TIME OF DEATH <i>10:30 AM</i>						
SIGNATURE OF PHYSICIAN <i>Wm. H. H. H.</i>								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7408

CERTIFICATE OF DEATH

Reg. Dist. No.

07420

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pemberton -Spring Hill Road				e. STREET ADDRESS -Pemberton-Spring Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM GUNBY SEABREASE				4. DATE OF DEATH Month Day Year JUNE 10 th 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Owner-Hardware Store			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME A. Lake Seabrease				14. MOTHER'S MAIDEN NAME Alfonsa Elliott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Anna E. Seabrease (Wife) Pemberton-Spring Hill Road-Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13 , 19 55 , to 6-10 , 19 58 , that I last saw the deceased alive on 6-10 , 19 58 , and that death occurred at 5:00A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED June 10 / 58							
ACTUAL SIGNATURE Earl L. Royer M.D.				PHYSICIAN'S NAME (Type) Dr. Earl L. Royer 407 Camden Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jun. 12, 1958		Wicomico Memorial Park		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. Seabrease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

NAME OF DECEASED [Illegible]		PLACE OF DEATH [Illegible]	
SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]	
NAME OF WITNESS [Illegible]		NAME OF REGISTRAR [Illegible]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the registrar, and the other copy to be sent to the health department.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07421

7435

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bd. of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hill		c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sandy Hill Beach			d. STREET ADDRESS 412 Mitchell St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AVERY Middle CRAWFORD Last SHOCKLEY			4. DATE OF DEATH Month June Day 1 Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1930		9. AGE (In years last birthday) 28 yrs. 0 Months 12 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chicken		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Avery C Shockley			14. MOTHER'S MAIDEN NAME Mary E. Phillips		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary E. Shockley (Mother) 412 Mitchell St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from boat to go swimming - Sank, and body not recovered for 4 days			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6-1-58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nanticoke River	
		20f. (City or town) nr. Sandy Hill		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Philip A. Insley		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-6-58	
EXAMINER'S NAME (Type) Dr. Philip A. Insley		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun. 7 /58		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
		22d. LOCATION (City, town, or county) R.D.# Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. RECEIVED BY REGISTRAR JUN 10 1958	
		DATE		24b. REGISTRAR'S SIGNATURE Quaker	

FOR STATE
HEALTH DEPT

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO COUNTY CLERK, A COPY OF THIS DEATH CERTIFICATE SHALL BE FURNISHED BY THE MISSISSIPPI STATE DEPARTMENT OF HEALTH, BIRMINGHAM, ALA. 35201.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7409

CERTIFICATE OF DEATH

07422

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY ACCOMACK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN IB 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hosp.				d. STREET ADDRESS WITHAMS 83X-3			
3. NAME OF DECEASED (Type or print) First Charles Middle S. Last Smith				4. DATE OF DEATH Month June Day 11 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 1, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME WILLIAM COSTIS SMITH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT C. STANLEY SMITH Address WITHAMS, VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Cerebral DUE TO (Probable) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 24h DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia; Osteomyelitis feet							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Schum M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED June 12, 1958			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-14-58		22c. NAME OF CEMETERY OR CREMATORY SMITH Family		22d. LOCATION (City, town, or county) (State) JENKINS BRIDGE, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson, Accomack Md. ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 17 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

CERTIFICATE OF DEATH

2002

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 10/15/1937		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF DEATH 11/10/2002		9. TIME OF DEATH 10:15 AM		10. PLACE OF DEATH Home	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. ICD-10 CODE I25.9		14. SIGNATURE OF PHYSICIAN [Signature]		15. SIGNATURE OF REGISTRAR [Signature]	
16. SIGNATURE OF NEXT OF KIN [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]	

TO BE FILLED BY THE REGISTRAR

1. NAME OF REGISTRAR
[Name]

2. ADDRESS
[Address]

3. CITY
[City]

4. STATE
[State]

5. ZIP CODE
[ZIP]

6. PHONE NUMBER
[Phone]

7. FAX NUMBER
[Fax]

8. E-MAIL ADDRESS
[Email]

9. SIGNATURE OF REGISTRAR
[Signature]

10. DATE
[Date]

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Middle Blvd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle WHITE Last SMITH		4. DATE OF DEATH Month 6 Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1890
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. James White		14. MOTHER'S MAIDEN NAME Georgia Ruark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. T. Smith, Sr.		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Carcinomatosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1, 1957 , to 6-8, 1958 , that I last saw the deceased alive on 6-8, 1958 , and that death occurred at 1:34 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 6/9/58			
ACTUAL SIGNATURE Wm. B. Smith M.D.		DATE SIGNED 6/9/58	
PHYSICIAN'S NAME (Type) Dr. William B. Smith, Medical Center Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/10/58	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24. REC'D BY REGISTRAR JUN 11 1958	
24b. REGISTRAR'S SIGNATURE Norman T. Baker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Goody's

1992

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home R F D # 1</u>		/ d. STREET ADDRESS <u>R F D # 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Rufus</u> Last <u>Stanford</u>		4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13. FATHER'S NAME <u>William Stanford</u>	
14. MOTHER'S MAIDEN NAME <u>Henrietta Banks</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elva Gualt, R F D # 1, Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease</u> (c) <u>Years.</u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>6-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MTCALVERY</u>		22d. LOCATION (City, town, or county) (State) <u>FRUITLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>West ROAD Salisbury Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	



THE STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

DATE OF DEATH
PLACE OF DEATH

AGE
SEX

EDUCATION
OCCUPATION

RELIGION
MARRIAGE

PREVIOUS ILLNESS
CAUSE OF DEATH

DATE OF BURIAL
PLACE OF BURIAL

NAME OF FUNERAL HOME
NAME OF MINISTER

NAME OF CLERGYMAN
NAME OF MINISTER

NAME OF CLERGYMAN
NAME OF MINISTER

NAME OF CLERGYMAN
NAME OF MINISTER

NAME OF CLERGYMAN
NAME OF MINISTER

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NAME OF CLERGYMAN
NAME OF MINISTER

NAME OF CLERGYMAN
NAME OF MINISTER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for date, place, age, sex, education, occupation, religion, marriage, previous illness, cause of death, date of burial, place of burial, name of funeral home, name of minister, name of clergyman, and name of physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7411

CERTIFICATE OF DEATH

Reg. Dist. No. 07425

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>BAY STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES Henry TURNER</u>		4. DATE OF DEATH Month Day Year <u>JUNE 17 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 13, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CRPT. JESSE TURNER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE GRIFFIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>MR. FLOYD TURNER, SALISBURY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Staphylococcal Enteritis, Carcinoma of Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>58</u> , to <u>6/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 17</u> , 19 <u>58</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hilg</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road, Salisbury, Md.</u>	
DATE SIGNED <u>JUN 18, 1958</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Buraye</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

18 BALTIMORE-HEALTH DEPARTMENT STATE AND MARYLAND

07426

7412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LARRY Middle CLINTON Last WARD		4. DATE OF DEATH Month JUNE Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (State or foreign country) R.D.# Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elijah Burton Ward		14. MOTHER'S MAIDEN NAME Lula Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 002X	
17. INFORMANT Mrs. Nora Ward (Wife)		18. ADDRESS 106 Tilghman St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1958 , to June 17, 1958 , that I last saw the deceased alive on June 17, 1958 , and that death occurred at 5:08 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED June 17, 1958			
ACTUAL SIGNATURE E.P. Ritchings M.D. _____		DATE SIGNED June 17, 1958	
PHYSICIAN'S NAME (Type) E.P. Ritchings		Pine Bluff State Hospital Salisbury, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jun 20, 1958	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR JUN 20 1958		24b. REGISTRAR'S SIGNATURE Ch. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

CERTIFICATE OF DEATH

1912

PLACE OF DEATH		RESIDENCE OF DECEASED	
At Home		Baltimore, Md.	
DATE OF DEATH		PLACE OF BURIAL	
April 10, 1912		St. Paul's Church	
AGE		SEX	
68		Male	
RACE		OCCUPATION	
White		Retired	
MARRIED		SINGLE	
Yes		No	
NAME OF DECEASED		NAME OF NEXT OF KIN	
John A. Smith		John A. Smith	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Failure		Natural	
DISEASE		SYMPTOMS	
Hypertension		Chest pain, shortness of breath	
PREVIOUS ILLNESS		DATE OF ONSET	
None		April 5, 1912	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
J. A. Smith		J. A. Smith	
DATE		PLACE	
April 10, 1912		Baltimore, Md.	

7413

CERTIFICATE OF DEATH

07427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 23X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First Middle Last <u>Waters</u>				4. DATE OF DEATH <u>June 29 1958</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 23, 1906</u> 52 yrs.	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repair</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John E. Waters</u>				14. MOTHER'S MAIDEN NAME <u>Florence G. Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>491X</u>			
17. INFORMANT <u>John E. Waters</u> Address <u>Pocomoke City, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Necrosis</u> DUE TO <u>203X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial pneumonia and Pulmonary Edema</u> DUE TO <u>3 day</u> (c) <u>Multiple Myeloma</u> DUE TO <u>3 day</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 24, 1958</u> , to <u>6-29-1958</u> , that I last saw the deceased alive on <u>6-29-1958</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>111 Davis Street</u> DATE SIGNED <u>6-29-58</u> ACTUAL SIGNATURE <u>Frank E. Poole</u> M.D. <u>Salisbury, Md.</u> PHYSICIAN'S NAME (Type) <u>Frank E. Poole</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Burial 7/3/58 Unionville Cem. Pocomoke City, Md

No
John E. Waters Secretary
Shoe Repair
Maryland
Florence G. Waters
John E. Waters, Pocomoke City, Md
N 2 A
* Mar 23, 1901 25

REF-2 Box 133

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIC

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07428

7414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, see: Birth Cert. et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>White</u> Last <u>White</u>			4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1956</u>		9. AGE (In years last birthday) <u>1</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Joan White</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Freeline White</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> 835X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child backed over by grandfather by car.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:10</u> a. m. p. m. <u>6-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard of home.</u>		20f. (City or town) <u>Fruitland</u>	(County) <u>Wicomico</u>
(State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. FUNERAL, CREMATION, or DISPOSAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eden, Cw</u>	
22d. LOCATION (City, town, or county) <u>Eden md</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Braker W. Welch</u>		ADDRESS <u>Eden, Cw</u>		24a. REG. BY REGISTRAR DATE <u>JUN 12 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Welch</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7437

CERTIFICATE OF DEATH

Reg. Dist. No. 07429

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 10 Columbia Avenue			
3. NAME OF DECEASED (Type or print) First Thomas Middle J. Last Whittington				4. DATE OF DEATH Month June Day 10 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min. 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY -		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Whittington			
14. MOTHER'S MAIDEN NAME Virginia Stevenson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Years							INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 58 , to June 10 , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 8:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital, Salisbury, Maryland DATE SIGNED 6/10/58							
ACTUAL SIGNATURE G. Kosmahly				PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	
22d. LOCATION (City, town, or county) Crisfield, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE JUN 13 '58			
24b. REGISTRAR'S SIGNATURE W. J. Search							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G231 7/18/58 ggi

Reg. Dist. No. 07430

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allen</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Eden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alonza</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>6-</u> Day <u>12-</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1906</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Dawson, Ga</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u> </u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>258-20-1898</u>	
17. INFORMANT <u>Emmieren Williams</u>		Address <u>Allen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to the immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u>Years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-14-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Allen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JUN 18 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07431

7416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1-HR.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		d. STREET ADDRESS <u>1 709 ALVIN AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GEN. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE WINGATE WILLIAMS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 27, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT LEE WINGATE</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-34-7723</u>	
17. INFORMANT <u>J. HERMAN WILLIAMS - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>8 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 57</u> , to <u>June 12, 1958</u> , that I last saw the deceased alive on <u>June 12, 1958</u> , and that death occurred at <u>3:17 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SALISBURY MARYLAND</u> DATE SIGNED <u>6/12/58</u> ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> NAME (Type) <u>Thomas C. Hill, Jr.</u> <u>224 N. DIXIE PINE BLUFF RD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>		24a. REC'D BY REGISTRAR <u>June 17 '58</u>	
ADDRESS <u>Salisbury, MD</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES B. BOND		65		M		W		1898		BALTIMORE		MD		USA		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1925		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA	
EDUCATION		SCHOOL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HIGH SCHOOL		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
OCCUPATION		BUSINESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
MANAGER		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
CAUSE OF DEATH		HEART		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
CORONARY		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
NATURAL		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
DATE OF DEATH		1963		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1963		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
PLACE OF DEATH		HOME		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
HOME		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
DATE OF REPORT		1963		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1963		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
REPORTED BY		DOCTOR		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
DOCTOR		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
SIGNATURE		DOCTOR		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
DOCTOR		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	
DATE OF SIGNATURE		1963		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	
1963		BALTIMORE		MD		USA		USA		BALTIMORE		MD		USA		BALTIMORE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Zadeck</u> Middle <u>B</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>6-</u> Day <u>3</u> Year <u>19 58</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 4, 1902</u>		9. AGE (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwork</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Millwork</u>				11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>											
13. FATHER'S NAME <u>Isaac Williams</u>				14. MOTHER'S MAIDEN NAME <u>Annie Penna</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Margaret Reel</u> Address <u>Delmar - Del.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to severed right iliac vessels-Sudden</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run over by a truck.</u>													
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. 6-3-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>RFD # 30</u>		20f. (City or town) <u>Willards</u> (County) <u>Wicomico</u> (State) <u>Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>6-3-58</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willards Cemetery</u>		22d. LOCATION (City, town, or county) <u>Willards</u> (State) <u>Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James - Millboro - Del.</u>				24a. REC'D BY REGISTRAR <u>W. E. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>											
DATE <u>JUN 9 '58</u>				DATE <u>JUN 9 '58</u>													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07433

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>523 CARRELTON AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILSON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 19 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17, 1958</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Krumm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Donald Wilson Salisbury Ind</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>58</u> , to <u>6/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/19</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u>		DATE SIGNED <u>6/19/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<u>burial June 20 1958</u>		<u>June 20 1958</u>	<u>Protest</u>		<u>Protest Ind.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver Krumm</u>			ADDRESS <u>Princess Ave, Ind</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
					DATE <u>JUN 30 1958</u>		

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